PROGRESS

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IN THIS ISSUE

- Teen-age Drinking: What To Do
- Recent Trends in Beverage Alcohol Sales
- Responsibilities of Medicine in Alcoholism
- Just One Little Drink Is Too Many For Some
- Some Drugs and Their Effects Reviewed
- AA and Outside Agencies—A Policy Review
- Alberta Launches Courses On Alcoholism

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Volume IV, Number 3 **CONTENTS** Edmonton, December, 1962

Page

Teen-age Drinking: What To Do *by Marvin A. Block, M.D.* 2
Recent Trends in Beverage Alcohol Sales *by W. E. Wilby* 4
Responsibilities of Medicine in Alcoholism *by Harold H. Gay, M.D.* .. 8
'Just One Little Drink' Is Too Many For Some *by Patricia Campbell* .. 12
Some Drugs and Their Effects Reviewed *by Eric Jacobsen, Ph.D., M.D.* 20
AA and Outside Agencies—A Policy Review *by J. Motyl* 27
Alberta Launches Courses On Alcoholism *by C. Robert Dickey* 32
Thoughts On Scholarship *by J. Motyl* 33
Foundation Activities 34

TEEN-AGE DRINKING: WHAT TO DO

by Marvin A. Block, M.D., Chairman, Committee on Alcoholism American Medical Association

THE AVERAGE young person in this country starts experimenting with drinking at about the age 17. There are subtle references to the subject, tastes now and then of alcoholic beverages, and trial runs with a little beer, wine, or a sip of a cocktail. The olive from a parent's martini may already have become a ritual.

How shall we go about teaching a teen-ager about drinking — the good points, if there are any, and the dangers which are obvious to most of us? How do we impress upon a youth what drinking means, its risks, its effects, and its dangers?

Everyone does not react alike. Some people should *never* drink. About 10 percent of all alcoholics, for instance, have trouble early in their lives, dating from the first drink. In some people, alcohol invariably produces adverse effects or always results in excessive drinking. It is obvious that such people should not drink at all, at any time, for their own sakes and their families'.

What of the others, however, those who do not have immediate adverse results? How are young people to learn that in alcohol we are dealing with a very powerful agent, which is used wisely and with control and propriety by some, but by others is used indiscriminately, without control and good judgment?

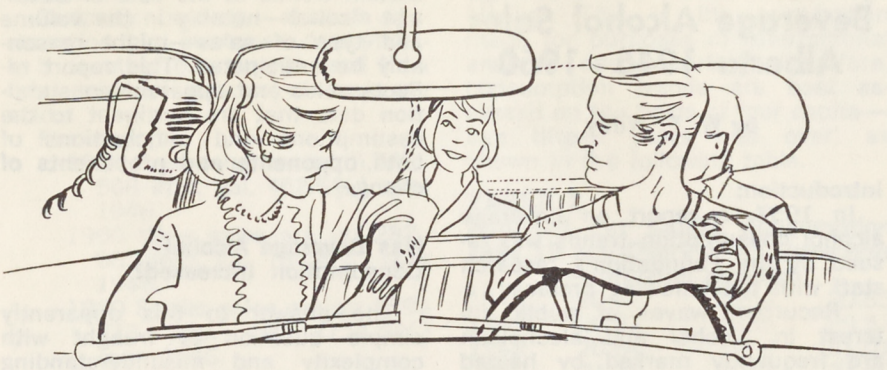
Alcohol can give a feeling of exhilaration, a sense of power, superiority, and grandiosity. But this power is unreal and elusive; it is the power of the alcohol, not of the drinker. When a person drinks only to get this power, there is danger.

IT IS IMPERATIVE that young people learn to live realistically in a real world. When they drink to get a lift, to enjoy the envy of their friends, or to acquire a sense of grandeur, they are drinking to escape into unreality. The euphoria, the feeling of well-being, the sense of increased power, the lack of care and responsibility — all of which is much more pleasant than facing drab reality—can be very attractive. But it is of no value when preparing for future living.

The basic values must be taught. The realization that with every act there is an accompanying responsibility and the necessity for assuming this responsibility must be the basic factor if a person is to drink.

It is urgent that every youth learn about alcohol, know its physiological actions in the body, know how his body reacts to it. If it affects him adversely, he should learn to avoid it, especially when such adversity comes consistently with his drinking.

If he can control his drinking so that at no time he allows the alcohol to control him, then he may use it as many do, in appropriate



social situations. If, however, he drinks for the effect it gives him, for the boost it gives his ego, for the courage he needs and without which he cannot face problems, then indeed alcohol is no longer a beverage, but a drug to give him something artificially which he does not himself possess.

These are the danger signs, and young people must be warned so they can recognize them.

EDUCATION in the public schools, particularly in high schools, should give our children the scientific facts about alcohol. These can be taught in many courses—general science, biology, physical education, health courses, as well as in the social sciences. The most important thing to be learned is that control is an absolute requirement. The slightest indication of loss of such control calls for complete abstinence.

Where drinking becomes a necessity in order to carry on, that individual should be detected early and taught how to face life's problems without depending upon a drug.

The respect for abstinence in others must also be learned by young people. Those who do not drink have a right to their abstinence without appearing inadequate. Refusal to drink by anyone must be considered a free choice, to be respected.

When such facts are generally taught, when the schools and the teachers in the schools understand the importance of the problem of alcoholism, and when the teaching is as seriously regarded for drinking as it is in many areas today regarding driving, then perhaps there will be sufficient knowledge disseminated so that alcoholism in future generations may be prevented.

(Reprinted courtesy of Marvin A. Block, M.D., Chairman, Committee on Alcoholism, American Medical Association.)

Recent Trends in Beverage Alcohol Sales Alberta 1946 - 1960

by W. E. Wilby

Introduction:

In 1957, a report on beverage alcohol consumption trends was issued by the Foundation's research staff with the following preface:

"Recurrent waves of public interest in alcohol and alcoholism are frequently marked by heated controversy rather than by constructive or sustained action. That the furor raised by these periodic drives is not effective, may be, in part, attributable to a paucity of factual information.

The Alcoholism Foundation of Alberta is constantly requested to relate the 'increasing consumption of alcohol' to a wide range of social problems; divorce, mental illness, traffic violations, juvenile delinquency and similar events.

Apart from the extreme difficulty of establishing a simple cause and effect relationship between alcohol and complex human behavior, the basic assumption that beverage alcohol consumption has increased markedly has not been proven."

It is now possible to compile updated figures concerning beverage alcohol sales and apparent consumption for the fifteen-year post-war period that has been marked by 'liberalized' liquor legislation.

In April 1957, the individual permit system was abolished. In February 1958, 'ladies and escorts' were permitted to consume beer in the licensed hotels of Edmonton and Calgary for the first time in thirty-one years. Also in 1958, new outlets were authorized to sell beer, wine and spirits for on-premises consumption.

Accompanying these changes, certain trends in the sale of beverage alcohol—notably in the volume and type of sales—might reasonably be anticipated. This report reflects sales and apparent consumption data that are pertinent to the assumptions and anticipations of both opponents and proponents of change.

Has Beverage Alcohol Consumption Increased?

The answer to this apparently simple question is fraught with complexity and misunderstanding seldom appreciated by lay observers. The major problem is that we do not know how many people drink; where, how, or how much. The only available statistics relate to beverage alcohol sales within Alberta, presumably for consumption in Alberta, by Albertans, in the year of such sales. Assumptions such as these must be made despite self-evident contradictions.

For example, tourists undoubtedly consume a sizeable though unidentified quantity of the beverage alcohol sold in this Province. Similarly, Albertans consume beverage alcohol outside the Province in unknown quantities. We know nothing of the volume of illicitly manufactured beverage alcohol consumed. Finally, the reported sales for a given period are not synonomous with consumption in that period: this is particularly true of stock purchased by authorized resale outlets.

Despite the theoretical defects and practical obstacles to determining precisely what is required to answer such questions as: 'Is drinking on the increase?' or 'Do we drink more than people in other areas — or at other times? — the data presented in this report are of value as guideposts to reality. They also provide an opportunity to illustrate the care with which

data must be manipulated and interpreted.

Certainly beverage alcohol consumption has increased dramatically if no other measure is used than total imperial gallons of beverage sold.

For example:

1960 Beer sales are up 5,749,508 imp. gal. (52.5%) over 1946.

1960 Wine sales are up 232,082 imp. gal. (84.4%) over 1946.

1960 Spirits sales are up 719,373 imp. gal. (174.8%) over 1946.

1960 Total sales are up 6,700,963 imp. gal. (57.5%) over 1946.

But, of course, the population has increased from 803,400 in 1946 to 1,283,000 in 1960 (a rise of 59.7%).

The following table reveals that per capita consumption of all beverage alcohol does not appear to have increased. Not only is per capita consumption in 1959 and 1960 below that of 1946; it is below the average of 14.47 gallons for the fifteen-year period.

TABLE 1

Apparent Per Capita Consumption of All Beverages—Imperial Gallons

1946	14.50	1954	13.91
1947	14.34	1955	13.78
1948	14.53	1956	14.03
1949	**14.86**	**1957**	**14.19**
1950	14.20	1958	14.79
1951	14.47	1959	14.45
1952	15.49	1960	14.30
1953	15.27		

The fallacy in this mechanical manipulation and interpretation is that 'per capita' here refers to every man, woman and child in Alberta. In fact we do not know how many men and women consume alcoholic beverages; nor do we know much about the consumption of children. One assumption that can be made is that persons under the age of fifteen years probably consume insignificant quantities of beverage alcohol. This is the assumption made for purposes of international analysis and reporting, therefore, consumption trends are best assessed on the basis of 'per capita—age fifteen years and over' as shown in the following table.

TABLE 2

Apparent Per Capita Consumption (Age 15 and Over) of All Beverages —Imperial Gallons

1946	20.34	1954	20.55
1947	20.27	1955	20.51
1948	20.64	1956	21.01
1949	**21.18**	**1957**	**21.40**
1950	20.35	1958	22.51
1951	20.83	1959	22.11
1952	22.48	1960	22.02
1953	22.35		

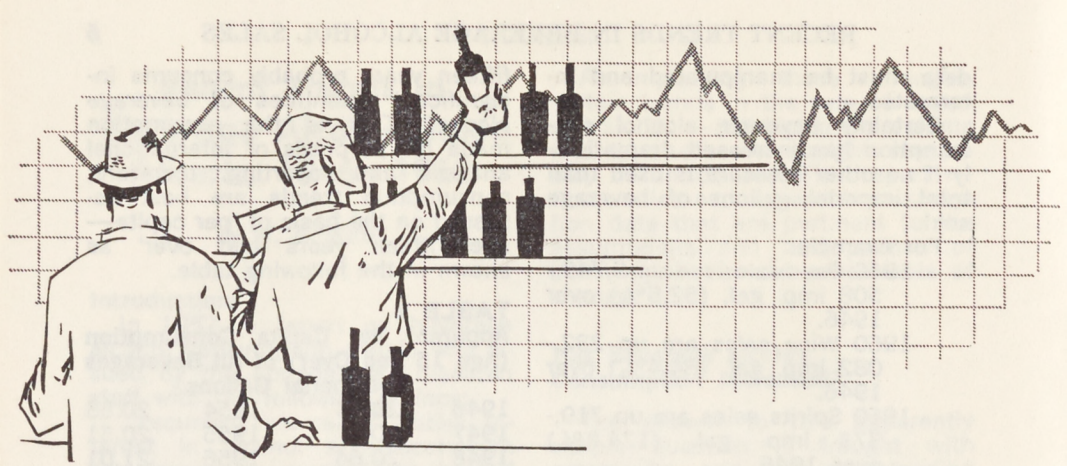
From these data it becomes clear that there has been an increase in consumption, however, a further refinement is necessary.

In many respects the per capita consumption of alcoholic beverages per se is of less significance than the per capita consumption of absolute alcohol. It is entirely possible to have an increase in per capita consumption of alcoholic beverages, yet a decrease in the amount of absolute alcohol ingested. For this reason, the internationally acceptable index of consumption refers to 'per capita, age fifteen years and over, consumption of absolute alcohol' as reflected in the following table.

TABLE 3

Apparent Per Capita Consumption (Age 15 and Over) of Absolute Alcohol—Imperial Gallons

1946	1.32	1954	1.49
1947	1.32	1955	1.51
1948	1.35	1956	1.55
1949	1.41	1957	1.59
1950	1.38	1958	1.65
1951	1.44	1959	1.64
1952	1.58	1960	1.64
1953	1.59		



From these data it will be noted that consumption has increased. The 1960 figure is an increase of 0.32 gallons of absolute alcohol over 1946, and an increase of 0.14 gallons over the average for the fifteen-year period. Whether such an increase is 'dramatic', and the source of many social ills attributed to or associated with drinking, remains a moot point.

One further note of caution is required. The per capita index is an 'average' useful for comparison over time, or between different areas. However, it is quite inappropriate to conclude that the 'average person' consumes a given amount.

What are Albertans' Preferences by Type of Beverage Consumed?

It was earlier stated that 'it is entirely possible to have an increase in per capita consumption of alcoholic beverages, yet a decrease in the amount of absolute alcohol ingested.' This could occur if drinking preferences turned from high alcoholic content beverages, such as distilled spirits, to such products as beer or table wine. On the assumption that the major deleterious effect of excessive drinking is attributable more to the amount of absolute alcohol ingested than to the volume of beverage, some countries have attempted to alter public preferences in favor of relatively low alcoholic content products. Since there is some evidence to suggest that alcohol related problems tend to be more prevalent in areas where per capita consumption of absolute alcohol is high, or where public preference is for high alcoholic content beverages, it is of interest to note changes in preference as reflected by Alberta sales.

The relative quantities—per cent of total imperial gallon sales—of beverage alcohol sales by type are shown in the following table.

TABLE No. 4

Per cent Contribution to Total Gallon Sales by Type of Beverage

Year	Beer	Wine	Spirits
1946	94.1%	2.4%	3.5%
1947	93.8%	2.6%	3.6%
1948	94.5%	1.5%	4.0%
1949	94.3%	1.5%	4.2%
1950	93.6%	1.8%	4.6%
1951	93.2%	1.9%	4.9%
1952	92.9%	2.0%	5.1%
1953	92.6%	2.0%	5.4%
1954	92.0%	2.3%	5.7%
1955	91.6%	2.4%	6.0%
1956	91.6%	2.3%	6.1%
1957	91.4%	2.5%	6.1%
1958	91.7%	2.4%	5.9%
1959	91.4%	2.5%	6.1%
1960	91.0%	2.8%	6.2%

The above data reduced to terms of per cent absolute alcohol contributed by type of beverage are pertinent.

TABLE No. 5
Per cent Contribution to Total Gallon Sales of Absolute Alcohol by Type of Beverage

Year	Beer	Wine	Spirits
1946	72.4%	5.8%	21.8%
1947	71.9%	6.4%	21.7%
1948	72.1%	3.7%	24.2%
1949	70.9%	3.6%	25.5%
1950	68.9%	4.2%	26.9%
1951	67.4%	4.5%	28.1%
1952	66.2%	4.5%	29.3%
1953	65.1%	4.6%	30.3%
1954	63.4%	5.1%	31.5%
1955	62.3%	5.2%	32.5%
1956	61.9%	5.0%	33.1%
1957	61.6%	5.3%	33.1%
1958	62.5%	5.2%	32.3%
1959	61.7%	5.3%	33.0%
1960	61.0%	5.9%	33.1%

Both of the foregoing tables indicate that Alberta is predominantly a beer consuming area, but it is also clear that there has been a change in preference over the period favoring distilled spirits. This change in preference was most marked from 1946 to 1956, and it is particularly interesting to note the relative 'levelling off' of the trend during the period of 'liberalized legislation' which includes establishment of new types of consumption outlets. It is entirely premature to conclude that new drinking freedom is responsible for the observed trends, but future data will be examined with interest in this respect.

Canadian and Provincial Beverage Alcohol Preferences

Preferences for certain types of beverage alcohol as reflected in sales data indicate that Canadians are predominantly beer drinkers.

An analysis of sales during the ten-year period, 1952-1961, reveals that 91.9% of all beverages sold is beer; 2.8% wine; 5.3% distilled spirits.

In terms of absolute alcohol, 64.5% is consumed in the form of beer; 6.3% from wine; 29.2% from spirits.

The Provincial preference for beer, wine and spirits, as indicated by their contribution to total absolute alcohol consumed, is reflected in the following rank order table.*

Rank	Beer (ab. alc.)
1 (highest)	Newfoundland
2	Quebec
3	Ontario
4	Manitoba
5	Alberta
6	Saskatchewan
7	British Columbia
8	Nova Scotia
9 (lowest)	New Brunswick
Wine (ab. alc.)	**Spirits (ab. alc.)**
New Brunswick	British Columbia
Nova Scotia	Nova Scotia
Saskatchewan	New Brunswick
Newfoundland	Alberta
Quebec	Saskatchewan
Ontario	Manitoba
Manitoba	Ontario
British Columbia	Quebec
Alberta	Newfoundland

*(Data for Prince Edward Island is not available)

Mr. W. E. Wilby has been Research Associate with The Alcoholism Foundation of Alberta since June, 1955. He is a graduate of the Universities of British Columbia and California, specializing in the field of Criminology. During his tenure with The Foundation, Mr. Wilby has been largely responsible for program assessment and planning, but has also devoted considerable time to a critical analysis of the mythology and misconceptions associated with problems of alcohol and alcoholism.

RESPONSIBILITIES OF MEDICINE IN ALCOHOLISM

by Harold H. Gay, M.D.
Chairman, Michigan State Board of Alcoholism

It is medicine's responsibility to accept alcoholism as an illness, admit alcoholics for treatment in general hospitals, and teach the facts about alcoholism in medical schools.

THERE has seemed to be in the past and, indeed, up to and into the present, a tendency on the part of scientific medicine to ignore the problem presented by the alcoholic. This has been in part, no doubt, the result of the fact that there are and have been in our society powerful forces which have isolated the alcoholic from community concern on sociological, moral, religious, and other grounds.

This is not a unique human pattern of behavior. The same attitudes have existed in the past in relation to the insane, in relation to oddities in human behavior, as during the witch hunts of early Colonial days, and, indeed, in relation to certain racial characteristics different from the dominant group.

However, it is not likely that even in the face of social disapproval the alcoholic would have been so completely ignored by scientific medicine if some of the criteria for recognizing and treating disease had been present in the instance of the disease (as we now recognize it) of alcoholism. The trained physician is most comfortable in the treatment setting if he can establish for any disease he is called upon to treat, a cause. He would like to know:

1. Is this a familial disease? Is it inherited or is the tendency inherited?

2. Is this a congenital disease? Is it a result of birth injury, of influences acting during pregnancy, etc.?

3. Is this disease due to external factors? Is it a germ disease: due to injury, poisoning, etc.?

4. Is this a degenerative disease? Is it due to a wearing out of vital tissues or organs; cancer, senility, etc.?

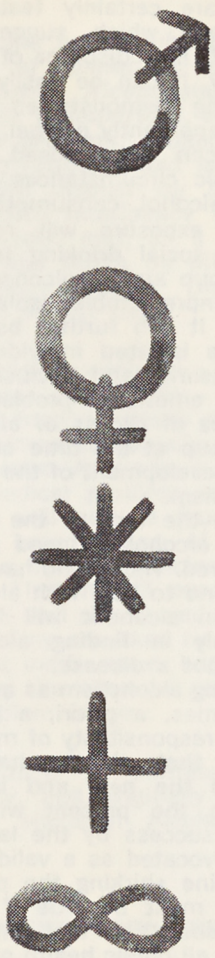
5. Is this an emotional disease? Is it a neurosis or insanity, etc.?

The physician looks upon all deviations from normal as disease, whether the deviation be in the realm of the physical, the physiological, or the psychological. It is unlikely that any thoughtful physician conversant with the facts would fail to recognize alcoholism as a disease. There are still many factors about this disease, however, which puzzle him and the first stumbling block is etiology.

The physician is aware that this is probably not a familial disease. It is certainly difficult to prove alcoholism to be an inheritable characteristic. Indeed, usually the opposite is the case.

The physician will find difficulty defining alcoholism as a physiological disease, though the first impulse may be to place it in this category considering it as an addiction. However, in the mind of the physician, addictions do not arise in isolated individuals from materials to which a major portion of the population is exposed. He considers a substance with potentials for producing addicition to be non-selective and capable of producing addiction in one and all exposed to its use.

The physician will find the least difficulty in looking upon alcoholism as a psychological illness, but even here he will find difficulty since he is told that the psychosis cannot be considered separate and aside from its association with alcohol—that the one does not exist without the other—and that splitting the alcohol off from the duo leaves a psychologically healthy, normal individual.



Cause Unknown

Stated simply, the physician considers alcoholism a very confusing disease, which could be, and usually was, said of every disease until its etiology was fully understood and treatment was placed on a sound scientific basis. The fact does remain, however, that alcoholism is truly a human disease. It must be accepted that the cause is as yet unknown.

There are certainly features of the disease which suggest that basically it is a disorder of human physiology. It can be easily and is daily being demonstrated that a group of apparently normal, healthy humans can be exposed to the same basic circumstances in relation to alcohol consumption and that the exposure will result in "normal" social drinking for most of the group and in alcoholism for certain unpredictable isolated individuals. It can further be shown that these isolated individuals are not necessarily and exclusively involved in emotional problems and frustrations in excess of all others in the group at the time of or before the development of the disease of alcoholism.

Indeed, the fact of the disease status of alcoholism need scarcely be belabored. Those who have come to know and to deal with alcoholics or with an alcoholic will find difficulty only in finding alcoholism anything but a disease.

Accepting alcoholism as a disease this becomes, a priori, a problem for and a responsibility of medicine. The fact that disease has been treated in the past and is being treated in the present with considerable success by the laity cannot be advocated as a valid reason for medicine shirking the problem; and, this must be true if for no other reason than that this most serious of all public health problems will not fully yield until an etiology (or perhaps etiologies) have been discovered as a base upon which to erect adequate and productive treatment regimens.

How must medicine proceed to meet the responsibilities created by alcoholism?

First, the known facts regarding this disease must be taught in medical schools. The social, the family, and the moral implications of the disease are now being taught in undergraduate disciplines. Medicine must not and cannot long afford not to teach the medical facts relating to the disease.

Teaching is, perhaps, the greatest known stimulus to inquiry. Many thoughtful people find it irritating, irksome, scientifically unscrupulous to teach half-truths or doubtful truths. This alone will stimulate certain people to devote their intellectual curiosity to the solution of the many questions raised by the known facts of the disease. From this, eventually will come solutions.

Second, hospital doors must be opened to the alcoholic. Many general hospitals already accept alcoholics as regular patients. All should do so. In the full light of sober reality, however, it must be recognized that no hospital can admit patients for treatment whom no one on its staff is able or willing to treat. To admit alcoholics simply for "drying out" purposes would be just as improper and just as indefensible as to admit diabetics for the sole purpose of reducing the blood sugar to normal or to admit acute appendicitis patients for the sole purpose of allaying their pain.

This means that somewhere in the community, as a beginning, there must be at least one physician who has the understanding to accept the alcoholic as a diseased person seeking help, perhaps unconsciously, but none the less seeking help. The concept of the person with an emotional problem seeking help unconsciously is familiar to every physician. To see in the alcoholic's determined, sometimes violent opposition to proffered help, an unconscious seeking for help in a troubled, fantastic world should present no great hurdle to the objective physician versed in the modern concept of human behavior.

Common Rationalization

The physician who concerns himself about the alcoholic will at first and inevitably be discouraged by failure and indeed this is the most commonly heard rationalization for refusal to become involved with the treatment of the alcoholic. Yet, there are few diseases where the physician does not willingly accept the expectation of a certain percentage of failure and this in areas where the sufferer is consciously anxious to be cured.

Who, among physicians, has not had the frustration of seeing a fully controlled stable diabetic admitted to the hospital in diabetic coma? What experienced physician has not seen or at least learned of an adequately controlled epileptic lying in public in a full blown grand mal convulsion. Failures? Yes and no. The ways of learning of the human mind and the human soul are devious and in every conviction lies a finite, not to be ignored, shadow of doubt. So the diabetic restored to health immediately doubts that he was ever ill—he tries to ignore his disease and fails. So the patient with a convulsive disorder doubts his disease, ignores his treatment and rediscovers in his misery that he is ill.

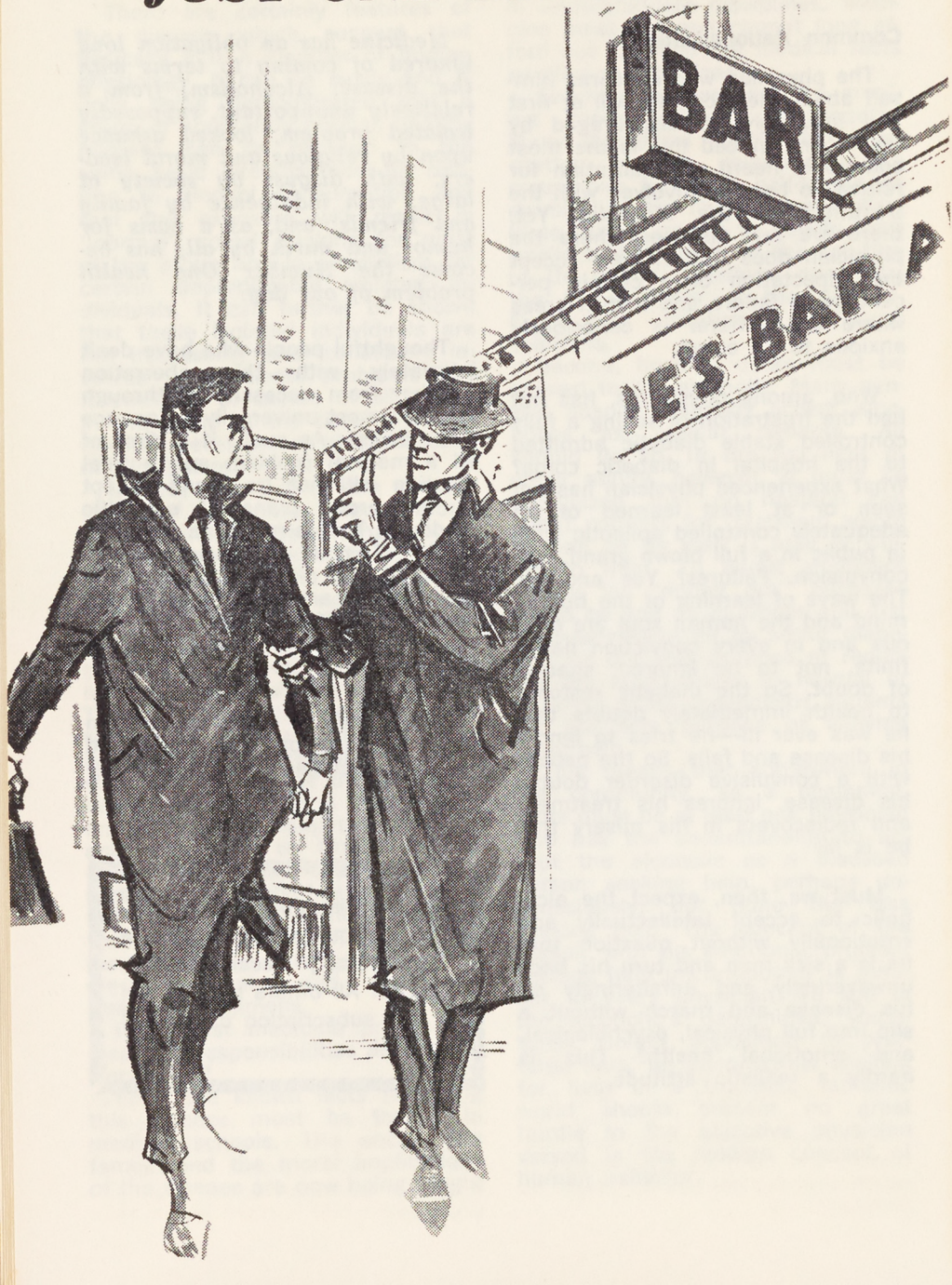
Must we, then, expect the alcoholic to accept intellectually and emotionally without question that he is a sick man and turn his back unwaveringly and unfalteringly on his disease and march without a slip into full physical, psychological, and emotional health? This is hardly a realistic attitude.

Medicine has an obligation long ignored of coming to terms with the disease. Alcoholism, from a relatively unimportant, supposedly isolated problem; looked askance upon by religious and moral leaders; with disgust by society at large; with indulgence by family and friends; and, as a basis for humor and mirth by all; has become the Number One health problem of our day.

Thoughtful people who have dealt intimately with this aberration whether from necessity or through choice almost universally pronounce it a disease. As such, it is first of all a medical problem and a final solution will not be found except in the broad plane of scientific medicine. This is medicine's responsibility. That it will eventually be accepted and discharged, none will doubt. Many are irked by delay and apparent indifference. Logically and properly, the time to get on with the problem is now.

(Reprinted by permission from Inventory, and originally published by the Michigan Alcoholism Review.)

'JUST ONE LITTLE DRINK'



IS TOO MANY FOR SOME

by Patricia Campbell, Staff Writer, The Edmonton Journal

THE MAN who told this story is tall and heavy-set. He has thick black hair. He wears horn-rimmed glasses and he has generous features.

He is an Edmonton man. You would recognize his name if you heard it.

He told the story sitting in his comfortable oak-panelled office. The room was as quietly impressive as the man himself. Occasionally, he paused to answer an inter-office telephone. His instructions were firm, decisive, the product of a well-honed intelligence. Integrity. Every situation well in hand. Solid as a rock.

Not quite. His case history occupies a file at The Alcoholism Foundation of Alberta.

His story:

My background is very ordinary. I was neither neglected nor overprotected. I had no unfortunate childhood experiences or any of that claptrap. My father was a minister. I had a brother and two sisters, and we all had a lot of togetherness, warmth, understanding and appreciation of one another.

A Social Drinker

I was about 23 when I took my first drink. It neither excited nor repelled me. I became a social drinker. But liquor was never important to me.

So for more than 20 years, I was an average drinker. Got drunk once in a while with the boys or at a weekend party, but that was it.

I was very fortunate in business. Head of a fairly large corporation which I had more or less built up from nothing.

I had a wife of whom I was very fond, two bright children and a beautiful home. I was very active in community life, on the executive of a dozen different organizations. A do-gooder, if you like, but I felt very strongly about my responsibility in these things and I found they gave me a great deal of satisfaction.

I was 44 before I had any trouble with alcohol. I began drinking to drunkenness more frequently than I had intended. But I was in my fifties before my life actually fell apart.

When I was 45 I had my first blackout. It was a pretty terrifying thing. I woke up in my bed—my own bed, fortunately—and I had no recollection of how I got there.

A Lost Night

I'd been at a stag party the night before. The car wasn't in the garage. I had no way of knowing whether the police had picked it up or I'd left it in the street or what.

I spent most of that day on the phone trying to find out, in oblique ways, what had happened. I finally found out two of my friends had had to carry me home.

That scared the daylights out of me. I went on the wagon then, and I stayed on it for two or three months.

But of course I started drinking again. And I had more and more blackouts. But they didn't keep me away from the bottle.

When I was 48, an impaired driving charge put me in jail for several days.

That was a bitter experience, let me tell you. But even that wasn't enough to stop me.

The idea that I might be an alco-

holic was inconceivable to me. Alcoholics were immature, inadequate people. I was a successful businessman, a community leader. Me? An alcoholic? The idea was preposterous.

Point To Prove

So of course, I had to prove I could handle this thing. I had to keep trying, over and over again.

And all the time my life was disintegrating. I'd get aggressive when I was drinking. Offensive. Invitations tapered off. People didn't come to our parties. My wife was humiliated. I'd promise. Never again. And I'd mean it. And the same night I'd be drunk again.

A drink would settle me down, I thought, never realizing that drink was causing the problems. People seemed to be turning against me. Rifts with friends, recriminations at home. The kids heard stories at school: "Your daddy's a drunk". They stopped bringing their friends to the house.

When I was 51, my wife left me. She'd had it.

Then my board of directors—all good friends—began to be critical of my work. There were rumors that I brought bottles to work. I was told to slow up, to take it easy. For an alcoholic, of course, there's no such thing.

One day I showed up at a directors' meeting pretty drunk. I got a severe vote of censure. It wasn't to happen again. It did. I was asked to resign.

Twelve Years Lost

I got another job right away. Not as good a job, but a pretty fair one. I stopped drinking for a while. I was pretty shocked. That job had been my whole life. Twelve years. I felt the firm was almost me, you know?

That second job lasted about a year. Then I lost it, and got another one. Not such a good one this time. A selling job. Then I lost it. And this went on for about three years.

I was not attending to business. I was drinking more and more. I got to the point where I was penniless—not only penniless but several thousands of dollars in debt. I was away behind in support payments to my family.

Was I heading for skid row? I expect that would have been the next step, all right.

But when I was 54, I came to Alcoholics Anonymous. And on the advice of one of the men I met there, I came to The Alcoholism Foundation.

I was completely beat. I had to drink. I couldn't seem to get through a day without it. I couldn't see any hope for myself. I was getting into the late stage of alcoholism, I know now. Very few reach that late stage. They die first.

I was thinking of doing away with myself. Death seemed the only way out. That's how far I had gone.

Even in this state, though, I felt compelled to try to treat the whole thing lightly when I came to The Foundation. When I arrived at the reception desk that first day, I said something flippant like, "Here I am. You can get the straightjacket out".

No Sympathy

I don't know what I expected. A sanctimonious approach, maybe, or the kind of thinly-veiled contempt I'd encountered in court.

Instead I found everybody at The Foundation very matter - of - fact, friendly and interested, but there was no evidence of sympathy or blame or even advice in our conversations.

Their attitude, of course, was based on the simple fact that I had an illness. That was something I didn't realize yet. But what a relief to discuss my drinking in a calm, reasonable way after all those years of one emotional crisis after another. Always before, the people I'd talked to had had a deeply personal involvement, either with me or with something I had done because of alcohol. No wonder I had never been able to view the problem with any sense of perspective.

I was assigned a counsellor, with whom I had regular private interviews. And I began attending the evening group therapy sessions.

Actual Illness

From then on it was a process of re-education. I learned that I had an actual illness. That I wasn't as guilty of heinous crimes as I thought I was. I'd been living so long with fear, anxiety, guilt—a sense of unworthiness.

This is one of the great things The Foundation did for me. It enabled me to forgive myself.

Gradually I gained an understanding of the illness, an understanding of myself, a clearer picture of my relations with other people. So much of it came into focus just by listening to the other people in the evening sessions.

There was such an obvious pattern to the experiences we had all gone through, you couldn't possibly miss it. One case history, written in general terms, would have covered the lot of us.

I had to unlearn dependence on alcohol and learn new ways—or relearn old ways—of handling problems and crisis. This, too, came gradually.

The toughest thing to get through my head, though, was that as an alcoholic, I could not take even one drink safely.

When you first stop drinking, people are constantly urging, "One little drink won't hurt you". Or, "You've been sober for such-and-such a time now. You **deserve** a drink."

Hosts and hostesses think they're being very hospitable, of course. Even doctors and psychiatrists don't recognize the danger in many cases.

But what they're doing is handing you a loaded pistol and urging you to play Russian Roulette.

6 Months' Treatment

I was in treatment for six months, at first two or three times a week and then once a week. At the evening group sessions, we spent most of our time discussing our past behavior and mental processes.

The group counsellor didn't do any preaching. He let us come up with our own ideas on ways of adjusting. And it worked. Most of us had, after all, once been fairly self-reliant people. My private counsellor and I got to the point where we often talked about politics, metaphysics, football or philosophy.

And yet, I always came away feeling helped.

In the end I no longer needed The Foundation. I was sober, I had a new job and I was making a great success of it. Everything was back on a firm footing.

It Didn't Last

That should be the end of the story, but it isn't, quite. After about two years I got maggots in the brain and I decided to become a social drinker. With the inevitable result. I fell right back into my former alcoholic pattern.

You'd wonder how a person could be that stupid, wouldn't you? Yet this is not uncommon among alcoholics. It's called a relapse.

After my first treatment the reservations began to creep in. I thought, maybe I'm not really an alcoholic. Here I've controlled myself for two years, built myself another good position. And all the time the resentment kept building up.

It's difficult for a non-alcoholic to visualize the resentment a man carries around when he is told he can never take another drink. It eats away at you.

Well, I lost that good job. And I lost the next one. In just a few months I was broke again. In debt again. Hopeless.

Finally, I recognized that I could do nothing by myself. I went back to AA and I went back to The Foundation.

That was four years ago. This time the comeback was much harder. It always is when you've had a relapse. I had to start much lower on the totem pole in business. I'm head of this firm now, but I just came to the job a few months ago.

I have a feeling, though, that my recovery is on a firmer foundation than before. The first time things came too easily for me. I jumped into that good job within a month of coming to The Foundation, made a great success of it and I thought I was doing it all myself.

Actually, of course, I had a great deal of help.

I feel that this time I got even more out of The Foundation. This time the load of guilt was heavier than it was before. You know the saying, "To whom much is given, from whom also shall much be required."

I felt that I had had many advantages, and what had I done with them? Thown my life away. And caused pain to many people, including those who meant the most to me. The load of guilt and remorse was almost intolerable.

But again, I was made to understand that it was the alcohol, and not an inherent weakness, that brought these things about.

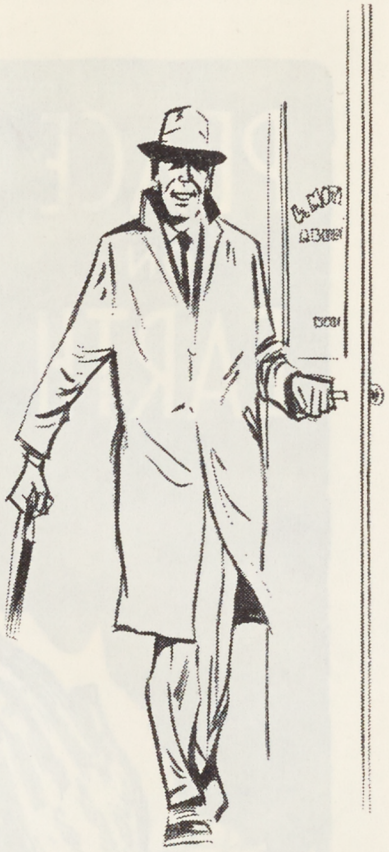
After all, alcoholics don't start out as immature, inadequate people. They became that way through their illness. And once I realized that I could become again what I once was, life began to open up.

Suddenly there's not just this one dependency, the bottle. There's a social life, fraternal organizations, clubs, hobbies. I began doing community work again. I'm on good terms with my wife, and I see my children often.

Gradually you can recover pretty well all that you've lost. Except that one thing.

You can never again take a social drink.

(Reprinted from The Edmonton Journal, November 14th, 1962, edition, by kind permission of the author and press.)



REASONS WHY?

Rationalizations for drinking are seldom as comprehensive as the following—and though it lacks sound reasoning it does have rhyme!

FIVE REASONS FOR DRINKING:

If all be true that I do think,
There are five reasons we should drink:
Good wine—a friend—or being dry,
Or lest we should be by and by—
Or any other reason why!

—H. Aldrich


PEACE
ON
EARTH
J. MOTYL

May there come to you at this

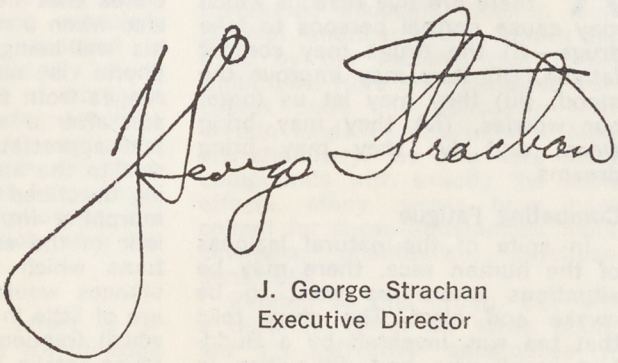
Christmas Time

all the precious things of life

Health, Happiness

and

Enduring Friendships



J. George Strachan
Executive Director

SOME DRUGS AND THEIR EFFECTS REVIEWED AND REASONS FOR ADDICTION CONSIDERED

by Eric Jacobsen, Ph.D., M.D.

APART FROM PURGATIVES, there are five reasons which may cause normal persons to take drugs—(i) the drugs may combat fatigue, (ii) they may improve the mood, (iii) they may let us forget our worries, (iv) they may bring sleep, and (v) they may bring dreams.

Combating Fatigue

In spite of the natural laziness of the human race, there may be situations where we want to be awake and alert. The story tells that tea was invented by a Buddhist monk who had difficulties in keeping himself awake during the night's meditations. Today's student has had the same experience with coffee. The Peruvian Indians chew cocoa leaves in order to endure hunger and fatigue, and soldiers in battle may be given amphetamine.

Improving One's Mood

Some drugs are able to improve the mood. If we are not depressed, have no nausea, no head-, tooth- or other ache we are not aware of our mood and, moreover, we do not care. But under the influence of certain drugs we may suddenly be conscious of a well-being, a feeling which may be so intense that it is as if every cell in the body is informing the central nervous system that everything is well and has never been so well before. This feeling is called euphoria, a Greek word composed of "eu"="good", "well", and "phero"="I bear", that is literally "well-being".

In medical usage "euphoria" means an unnatural feeling of well-being beyond what is justified by the situation. We talk about euphoria when a deadly ill patient declares that he is feeling well, and also when a normal person realizes his well-being. The feeling of euphoria is naturally varying, and ranges from the point where a person after a small dose of alcohol just appreciates that he is feeling well to the almost orgasm-like feeling described by morphinists taking morphine intravenously. Characteristic of the euphoric is that symptoms which under other circumstances would be very distressing are of little importance. The nausea which frequently occampanies morphine intake is unimportant to the morphinist.

Not a few drugs are able to induce euphoria; meprobamate, alcohol, amphetamine, morphine and cocaine, mentioned approximately

in the order of increasing activity, but the effect varies from individual to individual and with the way of administration.

To Erase One's Worries

It is well known that life is filled with worries. Some have a real background—the international situation, troubles in the family, or worries over the outcome of a serious disease. In other cases the causes for the worry are more imaginary, ranging from a slight feeling of mental insufficiency to the raging, paranoid and tragic jealousy of Shakespeare's Othello. Drugs having a calming influence on worries, true or imaginary, are called tranquilizers.

A suitable tranquilizing drug may make a patient with an advanced cancer be just as indifferent to his disease as if it were a complete stranger who suffered from it. No wonder then that worries without a real background also may be erased by the same kind of drug.

Although it is only ten years ago since the word "tranquilizer" was coined, the effect has been known for a much longer time. Alcohol has been taken for centuries in cases of stress. And more recently some of the barbiturates and especially meprobamate have produced a similar action. Undoubtedly much of the analgesic effect of morphine is due to its tranquilizing property. Many patients with severe pains state that the pains are still there after the morphine has been given, but their disturbing influence and the accompanying anxiety have disappeared.

Sleep-Inducing Drugs

The sleep-inducing effect is intimately linked to the tranquilizing effect. Worries and anxiety have a tendency to peep out when a man is left alone and is trying to sleep. Not only worries and anxiety may prevent sleep, but in many instances the mere thought that work the following day will be hampered by lack of sleep may keep the patient awake. A drug which is able to bring the person out of a vicious circle of this kind is more than welcome. The wish to have a refreshing sleep and to wake up in the morning fit to face new troubles fully explains the increasing demand for hypnotics in modern life.

Makers of Dreams

Dreams are not only found during sleep. They may also appear when a person is half awake, and even when he is in a state of full consciousness. Dreams may be defined as a more or less pronounced materialization of the thoughts. When this materialization is felt so vividly that we forget that they are fostered by our own brain, we speak about hallucinations. In this way a sliding scale is found reaching from pure thoughts to ideas falsely interpreted as realities. All steps on this scale may be provoked by drugs.

The meditations over a pipe of good tobacco may hardly be called dreams, but morphine gives intense day-dreams. True hallucinations, however, appear after the intake of other drugs, among which may be mentioned alkaloids isolated from Ceneral American drugs, known and used by the Indians long before Columbus. Here are mescaline from cactus buds and psilocybin from certain kinds of mushrooms. Modern chemistry has also here made compounds with exactly the same effects. Many names have been coined for these substances: hallucinogens, phantastica, psychosogens, etc.

Related to this group, but with a different effect on some points are the effective substances in marihuana. This drug is also able to give hallucinations, but besides, it releases a mental and physical energy which may seem desirable in some situations, as in helping to perform music or in dancing.

Undesired Side-Effects

Some of the drugs mentioned here are regarded as dangerous to such an extent that every possible measure is taken to prevent their use for non-medical purposes. One reason for this is that the drugs, in addition to their wanted properties, may produce side-effects which are dangerous for the individual or for society. We find side-effects which appear after a single dose, especially if it is too large or taken by an unaccustomed individual. Some types of acute side-effects are only disagreeable. Nausea and vomiting, after morphine, or hangover felt after alcohol, are purely private affairs of the consumer, but when the side-effects interfere with bodily or mental functions in such a way that this may endanger other people it is a different matter.

The muscular ataxia and the mental indifference found in individuals with a certain alcohol concentration in the blood make them completely unfit to handle every type of machinery, moving or stationary, on the ground, at sea and in the air. Other drugs, especially the sedatives and the tranquilizers may have a similar effect. Another example of an effect which may cause trouble for the individual or for society is the violent aggressiveness sometimes found after the consumption of marihuana.

Long-Term Side-Effects

The second type of side-effects are those which appear after chronic use and which may attack the mental and physical health of the consumer. The well-known symptoms of chronic alcoholism offer a typical example of the result of chronic and repeated use of a drug. The symptoms of the chronic morphinism and cocainism will be mentioned later.

Almost every drug, if used for a sufficiently long time in sufficiently large doses will cause symptoms, characteristic for this particular drug and different from that seen after other drugs. Most symptoms will appear in all patients if they take doses large enough and continue their consumption for a sufficiently long time. However, we also know of symptoms which will appear only in a certain number of consumers, relatively independently of dosage and time. It is presumably generally acknowledged that heavy cigarette smoking may provoke lung cancer, but it seems as if not every cigarette smoker will be attacked. Apparently he only increases his odds for getting lung cancer from about 1:10,000 to about 1:300.

Tend Toward Loss of Control

The main problem with most of these drugs is, however, that they may tempt people who once have started to take them to continue, to increase their consumption and finally to be unable to stop or even control their consumption. The addiction induced in this way assures that the side-effects from chronic intake cannot be avoided, and the following mental and physical deterioration offers further reason for society to attempt to prevent any consumption not medically indicated.

Factors Leading to Addiction

At least three factors lead to addiction with all its consequences, one is psychic and the two others are pharmacological.

An essential part of the psychic factor is that the consumer likes the effect of the drug. It is not necessary that the first experience is a hundred per cent pleasure. The first cigarette or the first drink are rarely a real pleasure. Most people get nausea and vomiting from the first dose of morphine. But if there has been at least some agreeable element in the effect, the temptation for a second try is obvious.

In order to induce addiction, the drug must appeal to the consumer in one way or another. It may either

induce euphoria, erase his worries or give him something he misses. He may, for example, lack the ability to make contact with his fellow men. Here, he can either take to agents like alcohol which facilitate the group feeling and make him feel as a part of a happy brotherhood. Or he can take an agent whose effect is to replace the group feeling as with morphine. Some people want new and exciting experiences in the form of dreams or fantasies able to carry them from this dull and troublesome world.

From Habit to Dependence

Once started, the use of a drug may become a habit, and once a habit, a psychic dependence is developed. This psychic dependence is presumably connected with conditioned reflexes; especially in the cases in which the drug consumption is linked to certain situations. Some persons are dying for a cigarette between the courses of a banquet, others must have a drink at certain hours of the day, etc. This type of dependence is not confined only to drugs but is found in many other human activities. Man has an inclination to exaggerate and sometimes follow a certain line beyond all sense; gambling, avarice, eating, sexual activities, hunting, and art-collecting are some examples of such activities not induced by drugs. They may not only increase to vices, but they may have social consequences and even lead to violation of civil or criminal laws. This is well known, and, therefore it is no wonder that the use of drugs with pleasant effects may increase to a point which seriously influences the victim's life. At this point, or even before, the pharmacological effects begin to play a role in the development of addiction.

Drug Tolerance

If a drug is given repeatedly at relatively short intervals, e.g. daily or at least every few days, the effect may decrease, and the doses have to be increased in order to maintain the effect. This phenomenon is called drug tolerance. After a certain pause in the administration, varying from drug to drug, the former reactivity is regained. Tolerance occurs with a large number of drugs, and is well known by pharmacologists and clinicians. Tolerance is found not only in drugs acting on the central nervous system, it may also be seen with drugs having a purely peripheral effect. Nitroglycerol may lose its effect in heart angina after prolonged use, and it may be necessary to discontinue its use for some days in order to restore its former effect. However, drugs having an effect on the central nervous system are the most liable to develop tolerance. The ease with which tolerance is developed and the degree it can attain varies much from drug to drug. Tolerance to the hypnotic effect of, for example, chloralhydrate requires a much more prolonged use than does the hallucinogenic effect of LSD. The second dose of the latter drug is almost eliminated if it is given within 24-48 hours after the first. The other extreme is cocaine which, according to the literature, gives a low tolerance.

One's Drug Another's Poison

The degree to which the tolerance maximally can be developed varies greatly from drug to drug. It is hardly known how much the concentration of a gas narcotic necessary to give narcosis must be increased by repeated administration, but it is presumably less than 25 per cent. In contrast to this the tolerance to morphine is able to reach such a degree that the daily dose of a morphinist may be several times the lethal dose for individuals not accustomed to morphine. The degree of tolerance obtainable with other drugs is placed

between these two end points. The tolerance does not only vary from drug to drug, but also within the different effects of the same drug. While the tolerance of the central nervous system towards morphine as mentioned may be extremely high, the tolerance towards the effect on the intestines, manifested by the constipation after morphine, is little pronounced. Such a variation of tolerance from symptom to symptom is found with almost every drug.

It is a general rule, although not without exceptions, that the central effects, especially the most desirable, such as euphoria or analgesia, are the most liable to tolerance, while the peripheral effects, such as constipation, increase of blood pressure and even headache, etc., are less liable. For this reason, the continued use of a drug may be less and less agreeable.

Tolerance Not Understood

The physiological mechanism behind the development of tolerance is still not cleared up. It is not due to the fact that the organism has developed a change of its metabolic processes causing the drug to be eliminated at a higher rate than before. The tolerance is an expression of a true increase of the susceptibility of the body towards the drug. The tolerance seems to be rather specific.

An alcoholic cannot take a larger dose of morphine than can a normal person. On the other hand drugs affecting the same functions within the central nervous system show *cross tolerance*. This means that an organism which has developed tolerance to one drug also shows tolerance to all other members of the same group. A man who has acquired tolerance to morphine will also show tolerance to methadone, even if he has never tasted this substance before in his life. The phenomenon of cross tolerance plays an important role in the testing of a new drug for morphine-like effects.

Two Possible Explanations

The tolerance found in the higher mental functions may be explained in two ways. One is that new pathways in the central nervous system are opened, leading around the centres which are totally or partly blocked by the drugs. More popularly said, this means that the individual consciously or unconsciously has learned to eliminate the effect of the drug. For a long time it was thus claimed that tolerance to alcohol was caused by the fact that the individual had learned to 'carry his drunkenness with dignity'. It is possible that this mechanism plays some role, but it is far from being the most important factor. Most probably the principal effect is found in a change in the biochemistry of each single cell.

There is a phenomenon in physiology called *homoistasis*. The body temperature is homoistatically regulated, and so is the composition of the blood together with thousands of other factors important for the organism. Homoistasis is a Greek word; derived from *homoios*: like, similar; and *stasis*: stand still, i.e., keeping the level. The body makes all efforts to maintain an optimal or at least a suitable level for its function. If some force is trying to disturb the equilibrium, a long series of counter-regulating functions are automatically working to re-establish the optimal level. This happens not only in the whole body but also within each single cell. If the metabolic equilibrium in this cell is disturbed, *incasu* by a drug, the proportion between the enzymes may be altered so that the disturbing influence is more or less eliminated. From this it follows that increasing doses are necessary in order to exert an effect. This point of view

is so far hypothetical but seems probable, especially because it is also able to explain the abstinence symptoms.

The Abstinence Symptoms

If an individual has used a drug in increasing doses for a long time and the administration of this drug is discontinued abruptly, abstinence symptoms may appear.

Such symptoms are of true somatic origin. They are not only psychic. It is true that psychic abstinence symptoms may be found. In their severest form, for example, the grief after loss of a strong emotional contact, they may even give somatic symptoms such as loss of appetite, precardial pains, palpitation, etc. But the abstinence symptoms discussed here are of a different origin. They are purely pharmacologically induced.

The nature of these symptoms varies from drug to drug. With morphine they are very violent, the vegetative regulation especially is disturbed, giving cardio-vascular disturbances with a fall in the blood pressure, cardiac symptoms, etc. These symptoms are combined with an extreme feeling of discomfort, much dreaded by the morphinists under treatment. And with some reason, the morphine abstinence symptoms may cause collapse, even death.

After the sedatives a different type of abstinence symptom is seen; here the susceptibility of the nerve cells in the brain is extremely increased, so that the abrupt discontinuation of the drug may release convulsions. This is found after the barbiturates, meprobamate, chlordiazepoxide and alcohol. A possible explanation of this hypersensitivity of the nervous system is that the increased susceptibility of the cells is suddenly manifested when the cells no longer are exposed to the drug.

Not all drugs cause abstinence symptoms to the same degree. As a general rule, it seems as if drugs with a sedative effect such as morphine, barbiturates and meprobamate show a higher tendency to cause abstinence symptoms than do the stimulating drugs, such as cocaine and amphetamine. In the treatment of addiction the dosage of the drugs which cause abstinence symptoms must be gradually decreased while drugs which give no abstinence symptoms may be discontinued from one day to another.

Characterization of Drugs

The drugs are characterized by a number of parameters the combination of which determines the extent of use, misuse and potential danger of a certain drug and with this the attitude of society, or the individual, toward this particular drug.

In the first place is the appeal of the drug to the individual. Some drugs only appeal to the few, e.g., phenacetine or antipyrine, others such as alcohol, tobacco and coffee appeal to the many. The appeal varies with many factors, some of which seem quite irrelevant. There are racial differences. Opium smoking, so popular in the Far East is extremely little used in the near East or among Europeans. Even within the same race the appeal may vary from place to place, from social layer to social layer, and from time to time. There seem to be fashions in the use of drugs just as in many other forms of human behavior, and when a thing is going to be fashionable, its use may spread like a prairie fire, both across whole continents and in small groups.

Drug Use Contagious

In this way the use of drugs may be extremely contagious. But not only that, misusers of a drug even seem to work actively for its propagation. Doctors who are mor-

phinists thus prescribe morphine very liberally and may thus help to create new addicts. In certain social circles, if a man has started to use a new drug and finds its effect exciting, he will do his uttermost to persuade the other members of the group to try.

The intensity of appeal does not always follow the popularity of appeal. It is sometimes seen that some drugs exert a very strong appeal to relatively few. Even if cocaine were freely available in the Western countries, I should guess that only five or perhaps 10 per cent would find it so pleasant that they would take it continually. But the few who would use it would become a very serious problem to society.

Euphoria and tranquilization are factors greatly influencing the appeal. The more intense these effects are the stronger the appeal. Combined, their effect on the appeal is still greater, as found with alcohol, morphine, and perhaps also with meprobamate.

An easily developed tolerance may influence the tendency to addiction in different ways. A too rapidly developed tolerance may prevent an addiction. It is beyond doubt that one of the main causes that the hallucinogens are so little addiction-provoking is the fact that they seem to have lost most of their agreeable effect already at the second dose if it is taken too shortly after the first. This is, however, an exception; generally, a rapidly induced tolerance leads the consumer to increase the dosage and thus causes a more rapid development of the chronic physical and mental illness which may follow the abuse of the drug.

Fear of Abstinence

The development of *abstinence symptoms* is the fourth factor which must be looked at when the potential danger of a drug is considered. Obviously the phenomenon of abstinence plays a great role in the development of drug addiction. It may be difficult enough to stop the intake of a drug which has become a habit, but when it is combined with true physical discomfort, the effort to stop the drug intake is made a hundred-fold more difficult, not only for the patient himself, but often the doctor who is going to treat him also faces a difficult task.

Undesired Effects

The last factor here is called the *undesired effects*. There are two types of such effects. Some drugs may induce the consumer to behave anti-socially. Some examples have been mentioned: The muscular ataxia which makes driving in a drunken state so dangerous, the extreme and uncontrolled violence which may be seen after marihuana, and the paranoic madness of the cocainist. It is natural that society's appraisal of a drug very much depends on the drug's ability to induce this type of side-effect.

The other type of undesired effects concern the individual's personal health. It is well-known that the chronic use of many drugs may cause a physical and mental deterioration which leads to invalidism. Especially in states with a well developed system of social welfare, steps must be taken against such drugs in order to prevent a need for the community to support a number of self-caused invalids and their families economically.

(Reprinted by kind permission of the Alcoholism and Drug Addiction Research Foundation of Ontario.)

AA and Outside Agencies -- A Policy Review

by J. Motyl

IT IS GRATIFYING to note that widening recognition of alcoholism as one of North America's major public health problems is bringing the identity, aims and contributions of Alcoholics Anonymous into clearer focus. However, a sizeable segment of the general public is still uninformed and misinformed about AA—about its structure, its services, and its attitudes towards other agencies in the field of alcoholism treatment.

An essentially spiritual society, AA is a lay organization of recovered and recovering alcoholics, without the formal structure of an administrative hierarchy typical of business organizations. The essential objective of Alcoholics Anonymous is to constantly bring the message of recovery to suffering alcoholics, and the first and perhaps most significant value which AA has to offer to each of its new members is the restoration of self-respect and human dignity.

EVERY AA member everywhere speaks with equal right and freedom on any AA business or concern, but all such expressions, whether or not they coincide with the overall views and traditions of AA, are held to be expressions of the individual member and not of other members or other groups of AA. No screening or investigation or selection is made of new applicants who wish to join AA. The only requirement for AA membership wherever AA carries its message of hope to alcoholics is: "I want to stop drinking—I want to stay sober."

A loving God, as manifest in the AA Group conscience, is the only authority, and AA tradition, evolved in the light of this faith and in the light of living experience, is the only guide to AA conduct. AA principles in helping alcoholics recover sobriety and to remain sober are derived essentially from life experience, i.e., AA holds to the empirical criteria: if it works it is accepted and used.

The 'Twelve Steps,' the 'Twelve Traditions' and the recently introduced 'Twelve Concepts of Service'—the latter approved at the AA General Service Conference in April 1962 — express the essence of many years of world-wide AA experience. And AA is bound by these traditions and guide-lines not to endorse, finance, or to lend the AA name to any alcoholism agency, clinic or activity outside AA, and cannot itself accept any outside financial support. Moreover, Alcoholics Anonymous cannot affiliate with, cannot participate in, or endorse any action which would create the impression of AA affiliation, or which would confuse AA identity with outside agencies or with other alcoholism treatment facilities.

Beyond these clearly defined reservations, AA is eager to cooperate with regional agencies, to supply information, and to exchange ideas and experiences, to broaden areas of common interest and agreement with the ultimate view of extending and accelerating help to sufferers of alcoholism everywhere.

MINOR conflicts of opinion, unimportant differences of basic views, are discouraged and deplored by the generality of AA membership whenever these are allowed to deter or side-track the mutual cooperation and understanding which AA seeks to establish in its contacts with legitimate outside alcoholism treatment agencies, both public and private.

As part of its ready contribution to this end, AA speakers are available to all organizations interested in alcoholism problems, and AA refers its own members to outside agencies for those services which AA is not set up to provide, e.g., medical treatment, hospitalization, psychiatric treatment, family counselling, and such emergency assistance as food, shelter and employment services, etc.

To quote briefly from one of AA's publications: "Within the framework of AA traditions, AA groups and individuals are free to cooperate in a helpful and friendly manner with outside organizations. AA members may be employed by or otherwise serve these organizations so long as they do so as individuals, not as members of AA."

The original aversion to anyone receiving payment for official AA work has long since been recognized as impractical and illogical. It is obvious that certain full time positions within the AA organization must be filled. And in many instances these are better filled by AA members who may be peculiarly and especially well qualified by their AA membership and experience to fill these positions. Such AA staff members have been accepted without reservation and are now highly respected by the AA membership generally.

SIMILAR prejudice against AAs 'selling' their AA membership and experience by accepting employment with regional and private agencies has also disappeared. It has been replaced by the recognition that in many instances the AA connections and experiences of such persons have contributed to their qualifications to do an even better job. Here again the only reservation which AA makes is that AA membership and the professional employment outside AA be kept separate and clearly defined in each case.

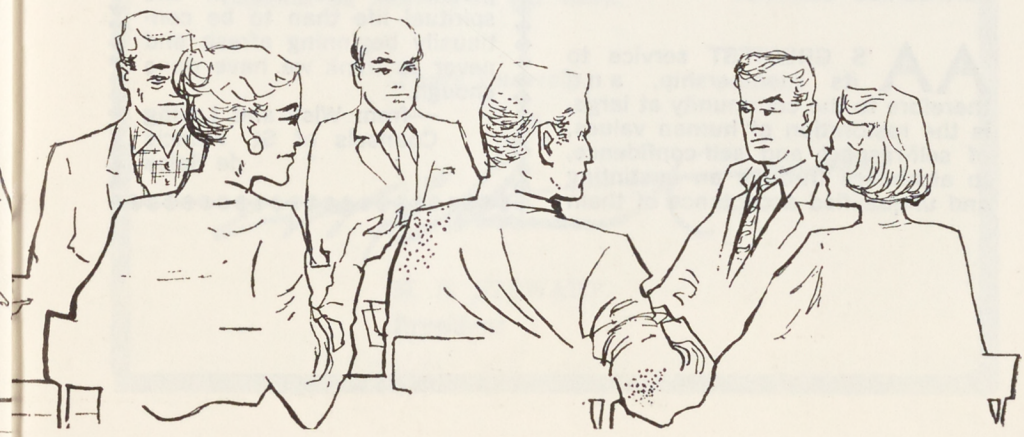
The old misconception based on a dwindling number of AA members' belief that AA therapy alone is always sufficient, that it provides all the answers and the only answers, and that only alcoholics can successfully work with alcoholic patients, is also withering away, and it no longer represents the views of the AA membership generally.

Quite legitimately, most AAs, as sober alcoholics, do believe that they have a peculiar ability to communicate effectively with other alcoholics, but they recognize at the same time that there are many alcoholics whom AA does not and cannot help, and that AA does not have all the answers. In many such cases experience has shown that various professional agencies have been able to help such alcoholics. This is recognized and appreciated by AA, and is the basis of AA's referral of such people to other agencies.

CLOSER liaison between AA and the professional clinics is therefore of paramount importance, and AA anticipates and welcomes such developments. Greater understanding of many mutual problems confronting all those in the field of alcoholism treatment will ultimately and inevitably result in better service both to sufferers of alcoholism specifically and to the community burdened by the costs of alcoholism generally.

The tendency of a small minority of AAs to down-grade the value of psychiatric, medical and hospital care is recognized but is gratifyingly diminishing. In all fairness to those few still holding these views, it must be admitted that such views have stemmed from real and disappointing experiences of such AA members in the aforementioned professional areas of treatment.

WITH REGARD to the use of sedative drugs, Alcoholics Anonymous do not question the prescribing doctor's ability—reservations in this area are again based on experience—and this centers essentially on the alcoholic's often questionable ability to stay faithfully with such treatment and to follow such prescriptions specifically. Too often experience has indicated the alcoholic's proneness to slip into excessive use of such drugs, and so to acquire another



kind of addiction or habituation. The following quote from AA literature illuminates this point clearly: "Alcoholics Anonymous is a program *for* alcoholics who seek freedom from alcohol. It is not a program *against* drugs. Only when tranquilizers and sedatives become a threat to the achievements and maintenance of sobriety do AA members become concerned with what has been called the 'pill problem.' The use of drugs has been a factor in some members' loss of sobriety. It has perhaps kept others from finding their way to AA sooner and more directly. Tens of thousands of men and women now in AA can testify that they needed no drugs to ease their entrance into a way of life without alcohol—and they have no desire to experiment with anything that threatens their present sobriety."

"The Fellowship of AA has never claimed to be the only instrument for helping problem drinkers, nor has it ever failed to appreciate the healing powers of its friends in Medicine. To these good friends we are grateful for their growing understanding of our special problem. For, as alcoholics, our experience suggests that if we are to remain free of one of the oldest drugs, alcohol, we should avoid the use of any drug that poses a threat to hard-earned sobriety."

AA'S GREATEST service to its membership, and therefore to the community at large, is the restoration of human values, of self-respect and self-confidence, to alcoholics through an unstinting and unqualified acceptance of them by an understanding fellowship of men and women eager to share their experiences, strengths and hopes. In AA every man and woman learns to rededicate himself or herself to sharing and to giving for its own sake, to finding fulfillment and true possession in such giving.

AA does not espouse or promote or align itself with any program of organized religion. Its identity and its strength spring from a spiritual program of universal dimensions transcending the narrow confines and conflicts of religious orthodoxy. It unites men and women of every creed, race and colour in the faith that alcoholics' problems may be solved through a sincere appeal to, and through the intervention of, a power greater than self. And AA has proven over and over again that men and women in every walk of life everywhere can be the instruments for channelling this power to heal and restore shattered lives.

"Be patient with every one but, above all, with yourself. I mean do not be disturbed because of your imperfections, and always rise bravely from a fall. I am glad that you make a daily new beginning; there is no better means of progress in the spiritual life than to be continually beginning afresh and never to think we have done enough."

—from Wise and Loving Counsels of St. Francis de Sales

Our President's Message

A voluntary organization will cease to exist if it has no members—even if it receives its financial support from some other source. We need our members in order that our program can be advanced and strengthened, through their knowledge and encouragement, throughout the length and breadth of our province.

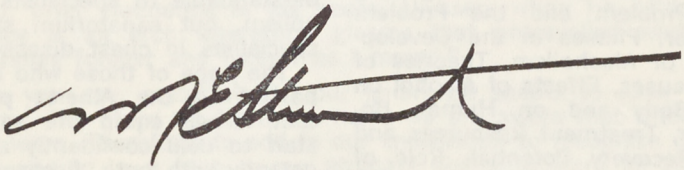
An organization such as ours is unlikely to obtain the detailed interest and support of the community at large. We can, however, obtain the detailed interest and the support of enough individual members of the community that the community at large will in time come to understand our program and its objectives.

It is recognized that an active membership is the strength of any individual agency; therefore, our search for members is not in conflict with The Foundation's participation in the United Funds of Calgary and Edmonton. These Funds actively encourage their member agencies to seek members.

Our bylaws provide that any person, company or association can become a member upon the payment of $5.00 or more. These monies are important in the financing of special items of expense in the areas of education, training and research.

We urge you to continue to be or to become a member of The Foundation. We urge you to suggest membership to your friends and acquaintances who indicate an interest in our work.

Yours sincerely,



M. E. STEWART
President

Alberta Launches Courses on Alcoholism

by C. Robert Dickey

THE EPIDEMIOLOGY of tuberculosis has been changing rapidly in recent years, and it has brought into sharper focus a problem which has been noted but largely ignored for at least a half century. This is the association of alcoholism and tuberculosis.

Alberta is pioneering ,in Canada, in one approach to the major difficulties posed by the combination of the two diseases in so many patients. A sustained programme of education for sanatorium staff has been launched.

The Division of Tuberculosis Control of the Alberta Department of Health, the medical superintendents of the sanatoria, Dr. H. H. Stephens and Dr. L. M. Mullen, have the assistance in this project of The Alcoholism Foundation of Alberta whose Education Service will provide the lectures.

The entire course of lectures comprises eight weekly one-hour sessions. The series is a continuing one, as each class is limited to 15 members of the sanatorium staff. It is expected that nearly a year will be required to cover the whole complement of staff who come in contact with patients.

Subjects covered in each series include:

Alcoholism—the Illness Concept, The Dual Illness — Alcoholism and Tuberculosis, Recognizing the Problem and the Problem Drinker, Phases in the Development of Alcoholism, Theories of the Causes, Effects of Alcohol on the Body and on Human Behavior, Treatment Resources and the Recovery Potential, Role of the Sanatorium Staff and the TB Associations.

FURTHER PLANS include a series of talks by Foundation speakers over the in-sanatorium radio installations, addressed to all patients. During this series problem drinking will be discussed in non-threatening terms, and confidential counselling will be offered to any who may wish it. Officials foresee at least a possibility that individual and group therapy will be practised, and a probability that Alcoholics Anonymous will be called on for help in maintaining recovery.

As long ago as the summer of 1959, the National Tuberculosis Association reported, "Alcoholism is one of the most important deterrents to effective tuberculosis control." The Association's conclusions: "It becomes clearer from year to year that the tuberculous alcoholic must be included in the planning and programming of TB Associations . . . If we neglect the treatment of alcoholism in dealing with an alcoholic tuberculosis patient, we are not treating tuberculosis adequately in terms of complete victory."

MANY scientifically - conducted surveys in sanatoria have made it clear that in many cases there are from two to three times as many problem drinkers among the patients as have been recognized by staff. This fact, and the reasons behind it, are readily understandable to specialists in alcoholism, but sanatorium staffs are specialists in chest diseases.

The hope of those who have embarked on the Alberta project is that it will equip the sanatorium staff to deal confidently and competently with both diseases.

(Reprinted courtesy of The Canadian Tuberculosis Association Bulletin, September, 1962, issue.)

THOUGHTS ON SCHOLARSHIP

. . . . and on learning about alcoholism

A STAFF MEMBER of The Alcoholism Foundation of Alberta was lecturing to a group of senior high school students on the causes of alcoholism. He pointed out that there are several possibilities of an as yet undetermined nature in this area. One particularly alert and bright young lady challenged him on this point repeatedly. "Well," she said, "it seems to me that, since the people in this alcoholism research have had twenty years or more to study these things, you should know all the answers by now".

There was real danger of losing the confidence of the entire group, who were now taking considerable interest in the lecturer's dilemma.

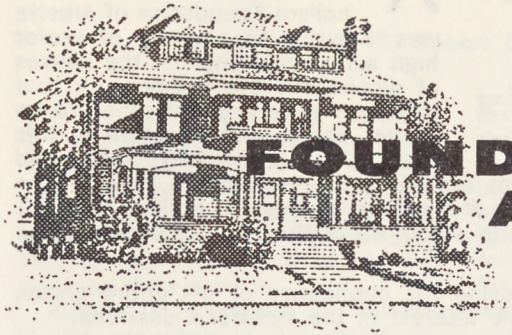
"The science of alcoholism research and treatment, like many other sciences today, is relatively young", the lecturer began. "At the same time, alcoholism is one of man's oldest afflictions. It is certain that it has plagued mankind for at least ten thousand years. It should therefore not be surprising that, while we know the answers to many questions in this field, there are even more questions remaining to which we do not yet know the answers. Moreover, the scope of pertinent inquiry increases with our knowledge, and with the growing intensity of the detail with which alcoholism confronts us in its complex physical, psychological and socio-cultural involvements."

"Let me illustrate this metaphorically. You are standing on a broad, flat plain, and you turn and look all about you. Because your eye, that is, your viewpoint, is relatively near the ground, your perception is limited to a radius of only a mile or two. The things you will observe and learn from this observation will not be many, and it will not take long to identify and assimilate and master them as an addition to your knowledge. Next, let us assume that you climb a hill a hundred yards high in the middle of this plain. Your view will expand several times over, and the increased amount of potential knowledge to be gained from this high vantage point will require considerably more time and study. Finally, if you climb a high mountain centered on this plain, your view will be so far-reaching that you will see not only all the plain but you will see valleys and rivers and hills beyond—possibly even other mountains. And there will be so much to see, so much to identify, so much to understand that the whole of a long lifetime might not be enough to add all that new knowledge to your learning."

"The great English poet, Lord Tennyson, expressed this thought with beautiful, brief eloquence in his poem, Ulysses, when he said: 'Yet all experience is an arch wherethro' gleams that untravelled world whose margin fades forever and forever as I move'."

"So you see, paradoxically, our ignorance seems to grow with our knowledge. The more we learn the more we are aware that there is ever more to learn. Therefore, to add to our knowledge, to recognize our shortcomings and to have faith in our ultimate ability to learn all things and solve all problems is at once the duty, the humility and the pride of scholarship."

J. Motyl



FOUNDATION ACTIVITIES

Staff Changes

Mrs. Myrna Guay, B.A. (Education) and M.A. (Guidance and Counselling) joined the Edmonton clinic staff as counsellor on October first. Dr. Oliva Gironella, Ph.D. (Psychology) joined The Foundation, also as counsellor, on November first. Dr. Gironella comes to us from the University of Alberta Department of Psychiatry where she had been staff psychologist. Mrs. Phyllis Downing, who for the past three years served as nurse at the Edmonton clinic, has been reclassified and is now a member of the clinic's counselling staff.

Mr. Allon W. Fraser, Director, Treatment Services, and for the past year also Director of Education, is now giving most of his time to The Foundation's clinical services, where the patient intake has recently grown considerably beyond previous treatment staff capacity. Miss Effie Cuthbertson has relieved Mr. Fraser of much of the educational burden in her new role as Supervisor of Education (Northern region).

The Foundation has lost the services of two outstanding members—Mr. C. Robert Dickey, Information Officer, and Mr. Timothy G. Coffey, Editor. Mr. Dickey, who joined A.F.A. in the Fall of 1959, left us on October 31st to become Executive Director of the Alberta Division of the Canadian Mental Health Association, with offices in Edmonton. Mr. Coffey left The Foundation on October 20th, after four years' service in publications production, to join the editorial staff of The Quarterly Journal of Alcohol Studies at Rutgers University, New Brunswick, New Jersey. Mr. Coffey's successor as Editor is Mr. John Motyl. We wish both Mr. Dickey and Mr. Coffey continued success in their new positions.

TREATMENT ACTIVITIES

July-September, 1962

Despite the usual Summer intake decline, the third quarter of 1962 was a busy one for counsellors at both the Edmonton and Calgary clinics. Edmonton recorded 89 new and re-activated patient files, plus 20 enquiries, while Calgary listed 72 new and re-activated patient files, plus 32 inquiries. A total of 1,938 interviews were carried out at the two clinics. Therapy group attendance at Edmonton and Calgary totalled 1,808, and it was noted that evening therapy groups were unexpectedly well attended during the Summer months. Group therapy activity at both centres is growing and group facilities are being expanded. The Lacombe group sessions continued actively, and an initial group series was begun at Red Deer in September.

RESEARCH ACTIVITIES

Fall, 1962

Major research effort during the Fall months has been directed toward final evaluation of studies initiated earlier in the year. Dr. Sommer's investigation of drinking patterns in Edmonton's licensed hotels has thrown a fresh light upon the comparative behavior of 'lone' and 'group' drinkers, and has provided many useful leads to further study. Two studies previously reported—The Patient's Perspective of Foundation Treatment, and, Social Perception of Female Patients—have been analyzed for conclusions that have practical value in program modification. In view of increasing inquiries concerning the effects of 'liberalized legislation' upon beverage alcohol sales and consumption, a detailed evaluation of Alberta trends since 1946 has been undertaken. Although there is a small increase in apparent consumption over the period, the magnitude of change does not appear to confirm some predictions of those who either opposed or favored change. The relationship of legislation to all facets of consumption will remain under observation and some interesting substudies are under consideration.

EDUCATION ACTIVITIES

October-December, 1962

During the last quarter, our Educational Services has been very active in many areas. Instruction about alcoholism has been given to many groups, and various media have been used to reach the public generally. Our interest in prevention has caused us to increase our activities among youth groups and in formal alcohol education in schools. The following list outlines education and information services for this quarter:

Medicine

Nursing Aides—2 sessions—Edmonton centre
Alberta Association of Registered Nurses—Provost, Bassano, Lethbridge
Aberhart Memorial Sanatorium, Baker Memorial Sanatorium—Aberhart concluded third session to doctors, nurses and administrative staff; Baker started first of series
Nurses from Calgary General and Holy Cross Hospitals continue orientation at Calgary centre
Treatment staff members, two from Edmonton, one from Calgary, attended Ponoka workshop entitled 'Role of the Psychiatric Nurse'
Occupational Health Nurses—orientation—Edmonton
Medical Secretary's Association—Edmonton
St. John's Ambulance Association—Edmonton
Nurses from Provincial Mental Institute, Oliver—2 sessions—Edmonton
Third-Year Medical Students, U. of A.—Edmonton

Education

Jasper Place Guidance Teachers—two-day seminar—Edmonton centre
Youth Advisory Committee of A.F.A., Edmonton, completed orientation series for Speakers' Bureau—now undertaking public speaking assignments
Leduc Teen Club (100)
H. A. Gray Home & School Assoc.
Grade 10 Students—Grande Prairie
Teenagers Seminar, Bowden—Bowteen Club and Bowmont Jaycees—Calgary

University LaSalle Club—Immaculate Conception Church—Edmonton
Students of Psychology Class—Crescent Heights High School—Calgary
Students of Physical Education Class, U. of A., 3 sessions—Calgary

Service Clubs

Lions Club—Lethbridge
Kinsmen Club—Lethbridge
West Edmonton Rotary Club—Edmonton
Kiwanis Club of West Edmonton
Rotary Club—Grande Prairie
Gyro Club—Lethbridge

Agencies

Agency Workers' Third Annual Seminar—sponsored jointly with Council of Community Services—3 days—Edmonton
Calgary Family Service Bureau
Association of Community Services—2 day seminar on Juvenile Delinquency—Calgary and Lethbridge staff—Lethbridge
Community Agency Workers' Seminar—Grande Prairie
Lethbridge Family Bureau Board

Young People

McDougall United Church Young People—2 sessions—Edmonton
St. Mark's Anglican Young People's Assoc.—Calgary

Air Force Personnel

Second Annual Week-long Seminar, R.C.A.F. Personnel—Cold Lake.

Law Enforcement

Southern Alberta Municipal Police Officers' Seminar—Calgary staff in cooperation with Calgary City Police

Church

West End Ministerial Assoc.—Edmonton
Lutheran Church Men's Club—Edmonton
United Church Women—Red Deer
Ogden United Church—Junior High Group—Calgary
St. Cyprian's Anglican Church Young People—Calgary
Kingsland Baptist Church W.A.—Calgary

Miscellaneous

Y.W.C.A. Groups
AA Groups
Television Publicity—"Face The Newsmen" CFRN-TV and "Gateway" CBC-TV—J. G. Strachan—Edmonton

The Foundation's expanding Education activities reflect increasing demands from both professional and public groups, and emphasize the growing recognition of alcoholism as a major socio-medical problem.

OTHER FOUNDATION SERVICES

- **ADVISORY SERVICES:**
  Professional advice and assistance on the problems of alcoholism

- **AUDIO-VISUAL AIDS:**
  Films, tapes, records, and displays are available on loan

- **CONFERENCES and SEMINARS:**
  To create a better understanding of the problems of alcoholism and methods of dealing with those problems

- **INDUSTRIAL WORKSHOPS:**
  For the education of management, supervisory staffs, and general employees in Alberta industry

- **ORIENTATION PROGRAMS:**
  For nurses, doctors, internes, penal officials, personnel managers, social workers, clergymen, teachers, and other groups

- **PUBLICATIONS:**
  Progress, Digest on Alcohol Studies, and original brochures and pamphlets

- **REFERENCE LIBRARY:**
  Books, pamphlets, and publications by authorities in the field of alcoholism

- **SPEAKERS' BUREAU:**
  For professional, industrial, church, social, school, civic, and other groups requesting information

The illustrations in Progress are by Harry Heine

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